Medical Examiner Practicalities

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Office of the Chief Medical Examiner
Tidewater District

§ 32.1-283: ME jurisdiction

- Trauma, injury, violence, poisoning, fire or unnatural manners
 - Suicide
 - Accident
 - Homicide (including terrorism, child & elder abuse)
- Unusual or suspicious

- In custody
 - DBHDS (mental health) custody
 - Jail, prison, correctional institution, police custody
- Unattended by doctor
- Suddenly and in apparent good health
- SIDS
- Cremation and burial at sea

Role of LME

- Examine the undressed body, complete body diagram, obtain toxicology specimens (including hospital samples), promptly sign DC, scene response
- Cremation authorization (CME-5)
- Seek consultation and assistance from the District office

LME Expectations

Professionalism

- Provide high quality service to the citizens of the Commonwealth while performing the duties of the Local Medical Examiner
- Confidentiality
- Availability
- Professional manner and dress
- Email addresses
- Maintain a unrestricted professional license and driver's license

LME Expectations Training

- Initial orientation at the district office
- Attend at least one LME conference every 3 years (term of appointment)
- Future: On-line annual training in TRAIN Virginia
- Contact district office for additional training, questions, or concerns
 - LME consultation

LME Expectations Death certificates

- Enroll in EDRS and certify all ME cases in EDRS
- Do not share login and pin information
- Certify the death certificate following the completion of an external examination

Death certificates

- Provide statistical information
 - Identify, plan and evaluate to improve public health
 - Apportion funding
- Family interest
 - Answers, closure
 - Cremation permit, transit permit
 - Estate settlement
 - Benefits and insurance
 - Funeral arrangements
- Legal, court interest

Completion of Death Certificate

- Death certificates shall be completed within 24 hours by a physician in charge of the patient's care if the medical examiner declines jurisdiction
- In the absence of a treating physician:
 - Partner, a nurse practitioner, physician assistant, the chief medical officer of the institution, hospitalists, ED physicians, or the autopsy physician
 - Physicians from bordering states may sign for their patients
- Certify cause of death
 - Best medical opinion
 - Civil immunity
 - Use black

The Medical Certification

ause of Death		Case#: 276779; Decedent: MELINDA
Enter the diseases, in	ions for entry of Cause of Death uries or complications-that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on a line. ause of Death has not yet been determined or is PENDING	
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Cause of death statements: General principals

- One condition per line
- Each condition should be caused by the one below
- Can combine temporally related conditions i.e., hypertensive and atherosclerotic cardiovascular disease
- Consider use of probable
- Qualify a specific COD with unknown natural cause i.e., gastrointestinal hemorrhage due to undetermined natural cause

Cause of death statements: General principals

- Mechanism or mode
 - The terminal physiologic event
 - Examples: Sepsis, exsanguination, organ failure, DIC
 - Cardiopulmonary, cardiac and respiratory arrest are descriptions of death
- Generally unnecessary
- Not sufficient as a sole cause

Cause of death

Immediate or dependent cause

- Final disease, injury or complication leading to death
- Complications or sequelae of the underlying cause
- Mechanisms or terminal conditions

Underlying or proximate cause

The disease, illness or injury that precipitated or initiated the chain of events leading to death

Other significant conditions

- Other significant conditions present at and which contributed but were not related to the immediate cause of death.
- Test is whether the person would have lived with if the primary COD had not killed the person

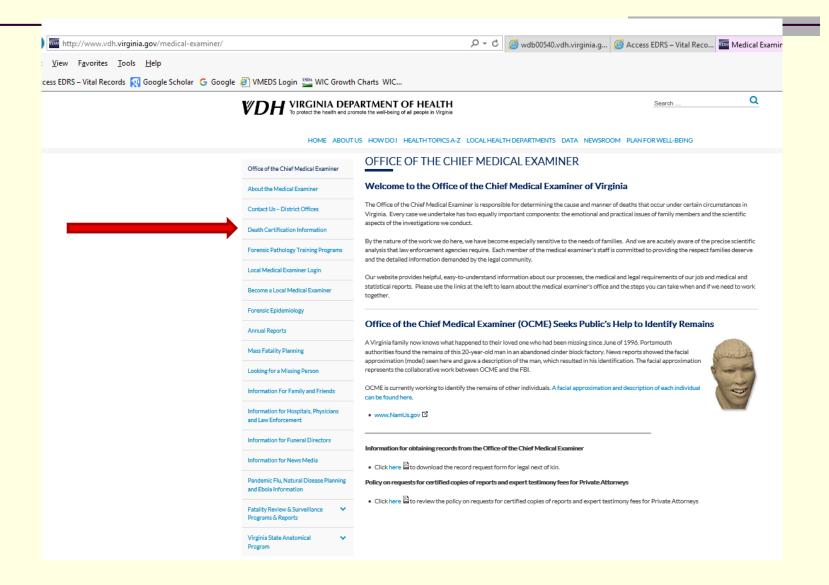
LME Certification of Death

- Based on the LME's physical examination (if no autopsy), medical history (including clinical review if applicable), and circumstances of death
- Do not use unknown or undetermined
- Pending used in consultation with the District
 - Do not add to Other Significant Conditions if the main COD is pending
- Death certificate amendments
 - Medical Certification portion only
 - Add incomplete information
 - Change or finalize existing Medical Certification because of after-coming information
 - Competed by the District Office

Physicians unwilling to sign

- Role of medical examiner
 - Evidence of current medical treatment
 - History, medicines, PMP, EMR
 - Ascertain the provider's discomfort
 - Ensure recognition of an unnatural death
 - Suggest possible COD based on treatment history
- Role of Local Health Directors & Local Registrars
- Call in turn downs

www.vdh.virginia.gov/medical-examiner

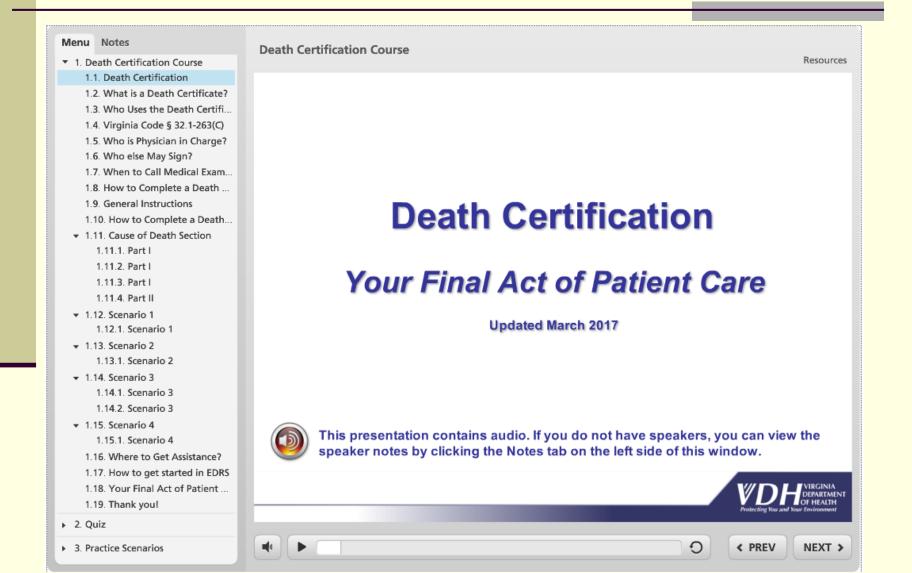


FAQ



Search DHP GO Contact Us Virginia Board of Medicine Board Home Death Certification **Board Members** Meetings & Minutes Doctors ' Profiles Read the letter from the State Health Commissioner and the Board of Medicine's Executive Director on the Completion of Death Certificates Renew Online Forms & Applications Death Certification in Virginia: Frequently Asked Questions Laws & Regulations Guidance Documents 1. As a physician licensed in Virginia, under what circumstances am I obligated to complete a death certificate? News letters By law in Virginia, you must complete a death certificate if you are the physician who was in charge of the patient's care for the illness or condition which resulted in death, unless the death was accepted for investigation by a medical examiner. D is ciplinary Proceedings When an investigation by the medical examiner is required, the medical examiner is required to determine cause of death and to complete the cause of death portion of the death certificate. FAQ Advis or v Boards 2. When should a death be reported to the medical examiner? Update MD/D O/DPM Profile Info Any death involving injury, trauma, poisoning, or deaths that are unexplained, sudden or suspicious in nature should be reported to the medical examiner. Deaths in correctional or state mental health facilities and deaths of persons not under the care of a Virginia physician should also be reported. Licens e Lookup Cas e Decis ions 3. Who is the "physician in charge" of a patient's care at the time of death? File a Complaint If you have been providing medical care for a patient, you are in charge of their care, even if you are not his or her primary care physician. Any physician who provides care of a patient for a significant disease process can be responsible for signing Administrative Proceedings the death certificate. This includes physician specialists who provide direct patient care. Prescription of medication for significant diseases, e.g. diabetes, hypertension, etc. is evidence of care. Division Staff Listing 4. Are physicians working in health care facilities as hospitalists or emergency room physicians required to sign death certificates? If an emergency room physician or a hospitalist pronounces the death of a patient or prescribes medication for a significant disease process, that physician is responsible for signing the death certificate. Virginia law is clear: "the physician last furnishing medical care to the deceased shall prepare and sign the medical certification portion of the death certificate." 1 5. Who else can sign a death certificate? The physician in charge of the patient's care for the illness or condition which resulted in death is primarily responsible. "In the absence of such physician or with his approval, the certificate may be completed and signed by the following: (i) another physician employed or engaged by the same professional practice; (ii) a physician assistant supervised by such physician; (iii) a nurse practitioner practicing as part of a patient care team; (iv) the chief medical officer or medical director, or his designee, of the institution, hospice, or nursing home in which death occurred; (v) a physician specializing in the delivery of health care to hospitalized or emergency department patients who is employed by or engaged by the facility where the death occurred; (vi) the physician who performed an autopsy upon the decedent; or (vii) an individual to whom the physician has delegated authority to complete and sign the certificate, if such individual has access to the medical history of the case and death is due to natural causes. "1

DC training



Letter from the VDH and DHP



COMMONWEALTH of VIRGINIA

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Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

August 1, 2014

www.dhp.virginia.gov TEL (804) 367-4400 FAX (804) 527-4475

Title: Completion of Death Certificates

Dear Clinician.

Many of you assist grieving families and assure that your patients' death certificates are completed in a timely manner. For that we thank you. However, there continue to be pockets of reluctance among some physicians to sign a death certificate which impacts families seeking the authority to proceed with the burial or cremation of a loved one.

Some of your patients will die at home and the family will need you to sign their loved one's death certificate as your last act of patient care. Of the 56,795 natural deaths occurring in Virginia during 2012, approximately 31% occurred at home. When a death occurs outside of a medical care facility (hospital, nursing home, etc.) local law enforcement often investigates the death to determine if there is evidence of an unnatural death (homicide, suicide, accident). Law enforcement may report these deaths to the medical examiner to allow them to confirm that the death is not a medical examiner case.

Most deaths that occur at home are not medical examiner cases. They are natural deaths from the typical chronic, progressive, or degenerative diseases such as hypertensive cardiovascular disease, atherosclerotic cardiovascular disease, diabetes, chronic obstructive pulmonary disease, or malignancy. For natural deaths, any health care provider who saw the patient or provided care (e.g., prescribed medication) for a patient's chronic illness or condition within the year prior to death is best informed to identify the "most probable" underlying cause of death and sign the death certificate.

The death certificate serves many extremely important purposes for the survivors of the deceased. This permanent legal record of vital information including demographics and the cause and manner of death is required for settling necessary affairs such as:

- · Burial or cremation
- · Accessing and/or closing bank accounts
- Probation of a will
- · Estate settlement
- · Obtaining proceeds from life insurance policies

Board of Audiology & Speech-Language Pathology – Board of Counseling – Board of Dentistry – Board of Funces Directors & Embalmers

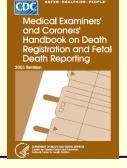
Board of Long-Term Care Administrators – Board of Medicine – Board of Physical Therapy – Board of Physical Therapy – Board of Psychology – Board of Social Work – Board of Veterinery Medicine

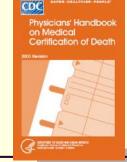
Board of Medit Professions

EDRS manual

ELECTRONIC DEATH REGISTRATION SYSTEM (EDRS) USER
MANUAL FOR
THE OFFICE OF THE CHIEF MEDICAL EXAMINER (OCME)
&
LOCAL MEDICAL EXAMINERS

Other resources





National Center for Health Stats:

https://www.cdc.gov/nchs/nvss/training-and-instructional-materials.htm

(includes COD reporting training (CME credits), link to mobile app (Apple and Android), links to the reference guides pictured above, etc.)

LME Expectations

External examinations

- Perform within 24 hours of district office notification
- If unable to complete the examination within the timeframe, immediately contact the district office
- Examinations only at the hospital and funeral homes
 - No external examinations at death scenes, Private homes, or nonfuneral home business locations
- Fully undress, remove marks of therapy, and personal effects prior to examination
- Document natural disease, scars, marks of therapy, tattoos, personal effects, clothing, and injuries
- Place body diagram, toxicology paperwork, and toxicology specimens in the postmortem specimen collection kit
 - Office expects within 3 days of completing the external examination

Call District Office with concerns

External examinations

What should give you concern?

- MDI reports suspected traumatic death
 - Review of pertinent medical records does not support a traumatic death
 - External exam shows no fatal trauma
- Unsuspected trauma in a suspected natural or overdose
 - If may indicate a different COD
 - Inflicted

Call the District

Autopsy Examinations

- Authorized by CME, ME (ACME's are LME's, too!), Commonwealth's Attorney, Circuit Court Judge (§ 32.1-285)
- Family requests
 - If ME case is a "view" or "external", the district office should be called by LME to discuss
 - If non-ME case, family will need to seek a private autopsy

LME Expectations Specimen collection

- 2 full tubes of blood,1 tube of vitreous humor, and urine if possible
- Notify the district office immediately if you're unable to collect adequate specimens
- Place specimens in the postmortem specimen collection kit with toxicology paperwork diagram

Specimen collection

- Hospital samples, still obtain postmortem samples
 - Insufficient hospital samples
 - Aftercoming allegations
 - Use for DNA sample
- Use of red tops, gray tops
- Urine used to confirm heroin
- Vitreous used to support BAC and confirm heroin
- Document blood source (femoral, sternal notch, precordial, subclavian, etc.) aids in interpretation
- Tighten, tighten, tighten the screw tops
- Label at time of exam

LME Expectations

Scene response

- Respond to the scene in a reasonable amount of time
- Survey the decedent at the scene without a full external examination
- Describing document evidence at the scene relating to the death as applicable
- Complete the death scene investigation report which includes a scene description and scene diagram
- Photographs to the district office via pre-arranged agreement
- Mail or delivered the paperwork to the district office within 24 hours of the scene response

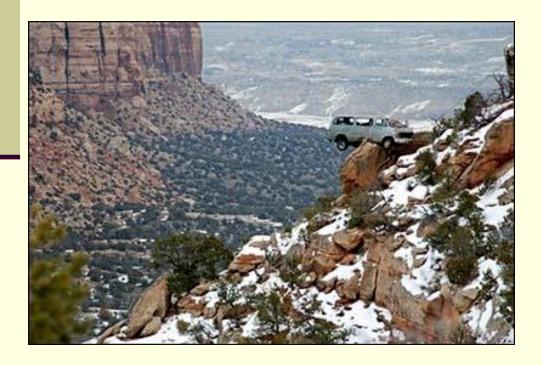
Scenes: When to go...

- LEA request
- Multiple decedents
- Secondary scene
- Hanging
- Covert burial*
- Time of death
- Personages
- Complex scene
 - Autoerotic
 - Serial killer

- Timing with police and funeral homes/removal services
- Cooperation with LEA

Scenes: When not to attend

- Inaccessibility of scene
- Crowd control issue
- Distance to scene
- Traffic congestion
- Practice responsibilities

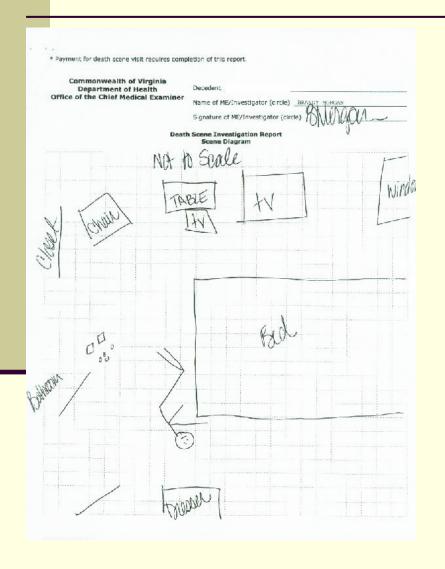


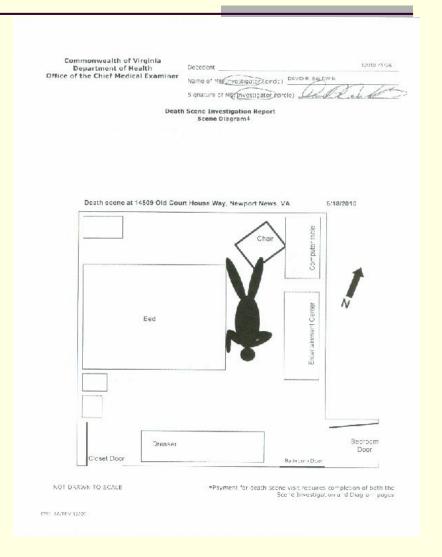
Inform the district office if you are unable to attend. It may be more feasible for an investigator to respond to the scene.

Importance of scene

- Narrative description
- Diagram
 - Gives context to narrative and photographs
 - Need both to allow for payment
- Photographs

Scene Diagrams





LME Expectations Cremation authorization

- Independent arrangements with funeral service providers
- Purpose: assure that no cases which should be Medical Examiner cases are cremated without proper investigation
- Conduct authorizations only at hospital, crematory, or funeral home
- Thorough examination of the undressed decedent without medical therapy
- Review the signed death certificate prior to signing a cremation certificate (continued...)

LME Expectations

Cremation authorization

- Question non-Medical DC containing a COD statement that may indicate a potential ME case
- COD statement is incomplete or contains only mechanisms, further inquiry is required
- Issues must be resolved before the authorization is signed and clarification may (should) be handwritten above the date line on the CME-5 form
- Cremation permit issued for deaths occurring in the Commonwealth of Virginia only
- Send copies of the CME-5 and signed DC to the district office within 5 business days

Cremation Review

- By review of the death certificate and examination of the body ensure that all potentially unnatural deaths are investigated prior to cremation
 - Permanent disposition
 - We want to you to "catch" unsuspected on unreported ME cases
- Properly certified death certificate signed by a physician
 - Clarify (and educate) attending physicians about incomplete and insufficient COD for cremation purposes
 - Document followup on cremation form
 - Not ME role to police or improve the death certificate
 - COD on DC and CME-5 should correlate
- Properly identified*
- Unclothed, examine all skin surface
- Only for deaths occurring in Virginia
- Required for fetal deaths investigated by ME, optional otherwise
- Attach copy of DC
- Refer FH to ME who signed the DC

"Blood" in the Head

- Intracranial and/or intracerebral hemorrhage
 - Likely trauma: subdural hemorrhage, epidural hemorrhage, intracerebral contusions
 - Natural: AVM, hemorrhagic metastasis, hemorrhagic stroke, subarachnoid hemorrhage/berry aneurysm, etc.
- Falls
 - Terminal collapse v trauma
 - Request an autopsy if you cannot tell from external examination or hospital studies

Hip fractures

- Traumatic fracture versus pathological fracture.
- Underlying cause versus contributing finding:
 - Does it belong in COD or contributing factors
 - Ask the attending if the death would have occurred in the absence of the fracture
 - Temporal relationship with recognized complication: postoperative pneumonia, sepsis, acute massive pulmonary embolism or previously present diseases exacerbated by the hip fracture
- If a hip fracture is a pathological fracture...
 - Attending physician should on GBDC and qualify as such
- If a hip fracture is significant condition but not resulting in death
 - Attending physician should list it in the contributing factors section
 - Add other co-morbidities such as osteoporosis in significant conditions
- If truly traumatic and the underlying cause, then RBDC

Mechanisms of death -Terminal physiological derangement

Sepsis, respiratory depression, cardiac dysrhythmia, hemorrhage, cardiac arrhythmia, cerebral hypoxia, cardiac arrest, respiratory arrest, pulmonary arrest, cardiopulmonary arrest, cardiac failure, heart failure, respiratory failure, kidney failure, hepatic failure, liver failure, end-stage liver disease, end-stage kidney disease, chronic kidney disease, respiratory insufficiency, cardiorenal syndrome, diastolic heart failure, systolic heart failure, exsanguination, septic shock, choking, hypothermia, hyperthermia, adult respiratory distress syndrome, diffuse alveolar damage, ventricular fibrillation/tachycardia, anoxic/hypoxic encephalopathy, aspiration, cerebral edema, failure to thrive, hepatorenal syndrome, shock, multisystem organ failure, status epilepticus, etc.

The problem with pneumonia

- While it's not a mechanism...
 - ...and it may be a primary disease process, i.e., lobar pneumonia due to Streptococcus pneumoniae
 - It may be secondary (and often is, particularly in hospitalized patients)

Pneumonia examples

Natural

- Postobstructive pneumonia due to lung cancer (natural, non-ME)
- Bronchpneumonia due to complications of influenza A (natural, non-ME)
- Aspiration pneumonia due to multi-infarct dementia (natural, non-ME)
- Hospital acquired pneumonia due to complications of cholecystectomy due to gangrenous cholecystitis (natural, non-ME)

Unnatural

- Bilateral aspiration pneumonia due to persistent vegetative state due to complications of blunt force head injury (ME case)
- Hospital acquired pneumonia due to complications of gunshot wound to the abdomen (ME case)
- Bronchopneumonia and sepsis due to neurogenic bladder and decubitus ulcers due to quadriplegia following remote cervical spine fracture (ME case)
- Aspiration pneumonia due to anoxic encephalopathy due to drug overdose

Cremation reviews, I have seen

- Septic shock, infected pressure ulcer
- Cardiac arrest due to hypertension due to pulmonary edema due to liver failure
- Renal failure due to hip fracture
- Recurrent pleural effusion due to sepsis due to pneumonia
- Cardiopulmonary arrest, bilateral pulmonary embolism
- Multisystem organ failure, hypotension, shock
- Severe sepsis, lithium toxicity, congestive heart failure
- Paraplegia due to MVA
- Intracranial hemorrhage
- Pulmonary embolism, deep vein thrombosis
- End stage liver disease
- End stage renal disease
- Cardiorenal syndrome due to acute severe combined systolic and diastolic heart failure
- Septic shock due to C. difficile colitis due to multisystem organ failure related to sepsis
- Septic shock due to acute on chronic respiratory failure due to pneumonia
- Acute on chronic respiratory failure, pulmonary edema, diastolic heart failure
- Multisystem organ failure due to septic shock due to respiratory failure

Cremation reviews, I have seen, continued

- Advanced stage due to malnutrition due to recent left sacrum and pubic rami fractures
- Pneumonia, CVA, ASVD, subdural hematoma
- Intracerebral hemorrhage due to cerebral air embolism due to AML
- Arrhythmia due to cardiac arrest
- Aspiration pneumonia due to respiratory failure with severe malnourishment contributing
- Protein calorie malnutrition
- Comfort measures due to chronic respiratory failure due to end stage renal disease due to massive sacral decubitus ulcer
- Septic shock due to acute on chronic respiratory failure due to end stage renal disease due to calciphylaxis
- Multisystem organ failure
- Pulmonary embolism
- Subarachnoid hemorrhage
- Cardiac arrest, hypoxic encephalopathy
- Airway obstruction due to coronary artery disease, CVA, ALS
- Cardiopulmonary arrest, primary cardiac failure, fluid overload
- Pneumonia due to debility due to pelvic fracture
- Pending

Cremation reviews, I have seen, continued

- Sepsis due to multiple skin was due to protein calorie malnutrition
- Anoxic encephalopathy, sepsis, acute systolic heart failure, massive bilateral pulmonary embolism, multisystem organ failure
- Alcohol intoxication
- Septic shock due to failure to thrive due to acute kidney injury due to paraplegia
- Chronic respiratory failure due to seizure disorder due to anoxic encephalopathy/vegetative state due to cardiopulmonary arrest
- Asphyxia, aspiration
- Inanition
- Hemorrhagic shock, narcotics/NSAID use
- Pneumonia, pulmonary insufficiency
- Cardiac arrest due to acute respiratory failure due to C. difficile with malnutrition
- Sepsis from pneumonia and UTI
- Respiratory arrest due to cystic degeneration of the brain
- Asystole of unknown origin with anoxic brain injury and respiratory failure
- ARDS
- Upper GI bleed due to hypotension due to chronic kidney disease due to hypothermia
- Pneumonia due to kidney failure
- Pneumonia

Cremation reviews, I have seen, continued

- SUDEP, seizures
- Septic shock due to pneumonia due to respiratory failure
- Acute hypoxic respiratory failure due to bilateral pneumonia due to coagulopathy due to septic shock
- Cardiac arrest, septic shock, acute respiratory failure, acute renal failure
- Liver failure due to metabolic acidosis
- Failure to thrive
- Acute renal failure due to aspiration pneumonia
- Hypoxic encephalopathy due to heroin and polysubstance abuse due to MRSA tracheitis due to nicotine abuse
- Pulmonary embolism and multisystem organ failure
- Respiratory failure
- Ventricular fibrillation
- Severe sepsis due to Pseudomonas bacteremia
- Sepsis, decubitus ulcer, renal failure
- Cardiac arrest
- End stage liver failure
- Septic shock and multiorgan failure
- Failure to thrive
- Cardiogenic shock

CDC Physician's Handbook, 2003

When processes such as the following are reported, additional information about the etiology should be reported:

Abscess

Abdominal hemorrhage

Adhesions

Adult respiratory distress

syndrome

Acute myocardial infarction

Altered mental status

Anemia

Anoxia Anoxic encephalopathy

Arrhythmia Ascites

Aspiration

Atrial fibrillation

Bacteremia

Bedridden

Biliary obstruction Bowel obstruction

Brain injury

Brain stem herniation

Carcinogenesis

Carcinomatosis

Cardiac arrest

Cardiac dysrhythmia

Cardiomyopathy

Cardiopulmonary arrest

Cellulitis

Cerebral edema

Cerebrovascular accident

Cerebellar tonsillar herniation

Chronic bedridden state

Cirrhosis

Coagulopathy

Compression fracture

Congestive heart failure

Convulsions

Decubiti

Dehydration

Dementia (when not otherwise specified)

Diarrhea

Disseminated intra vascular

coagulopathy

Dysrhythmia

End-stage liver disease

End-stage renal disease

Epidural hematoma

Exsanguination

Failure to thrive

Fracture Gangrene

Gastrointestinal

hemorrhage

Heart failure

Hemothorax

Hepatic failure

Hepatitis

Hepatorenal syndrome

Hyperglycemia

Hyperkalemia

Hypovolemic shock

Hyponatremia

Hypotension

Immunosuppression Increased intra cranial

pressure

Intra cranial hemorrhage

Malnutrition

Metabolic encephalopathy

Multiorgan failure

Multisystem organ failure

Myocardial infarction

Necrotizing soft-tissue

infection

Cld age

Open (or closed) head

injury

Pancytopenia

Paralysis

Perforated gallbladder

Peritonitis

Pleural effusions

Pneumonia

Pulmonary arrest

Pulmonary edema

Pulmonary embolism

Pulmonary insufficiency

Renal failure

Respiratory arrest

Seizures

Sepsis

Septic shock

Shock

Starvation

Subdural hematoma

Subarachnoid

hemorrhage

Sudden death

Thrombocytopenia

Uncal herniation

Urinary tract infection

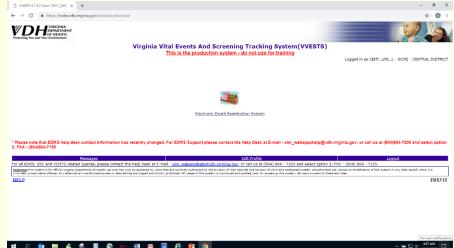
Ventricular fibrillation

Ventricular tachycardia

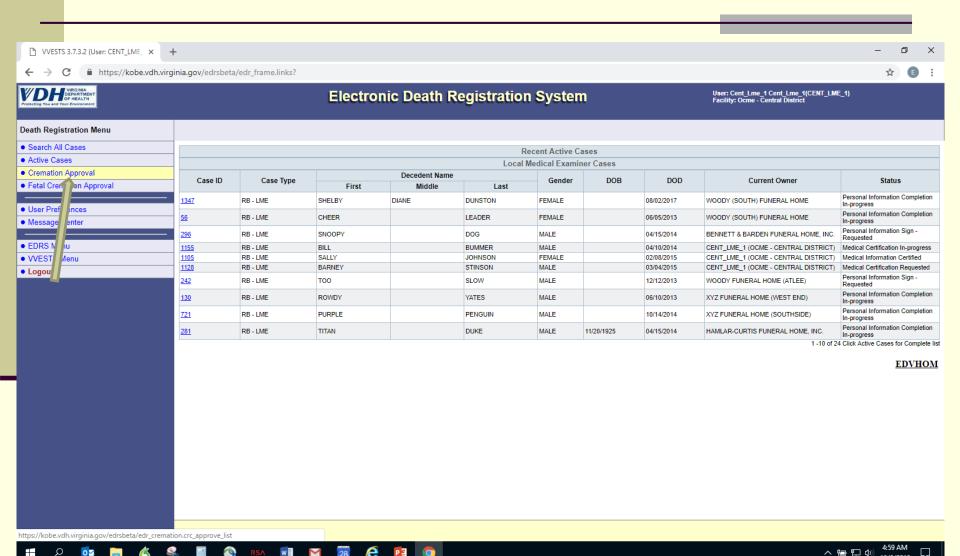
Volume depletion

EDRS LME cremation approval requested by FH

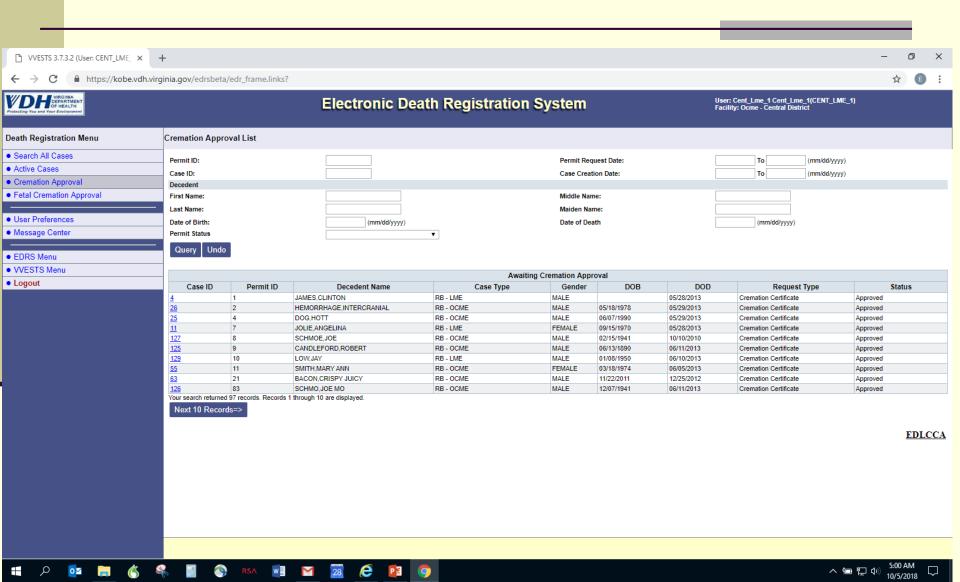




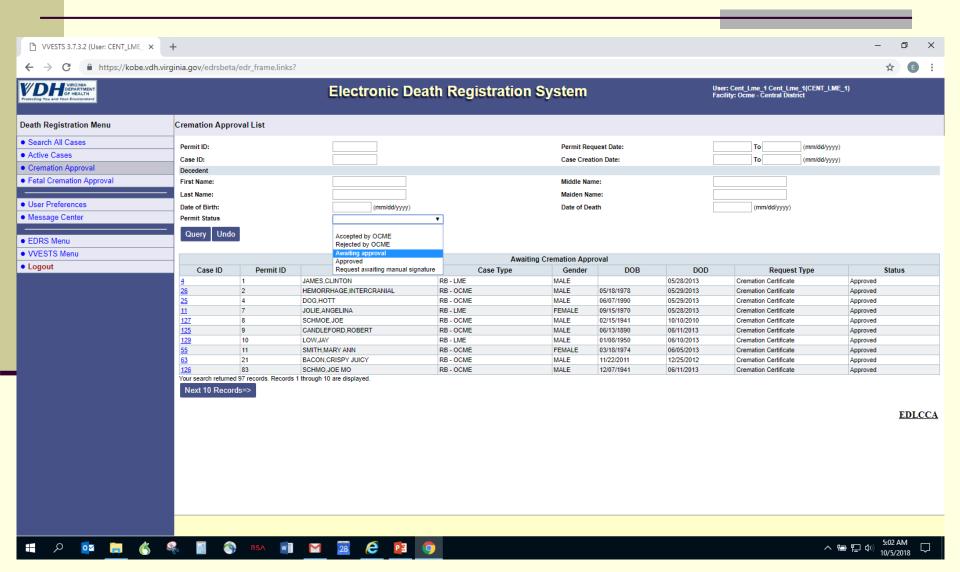
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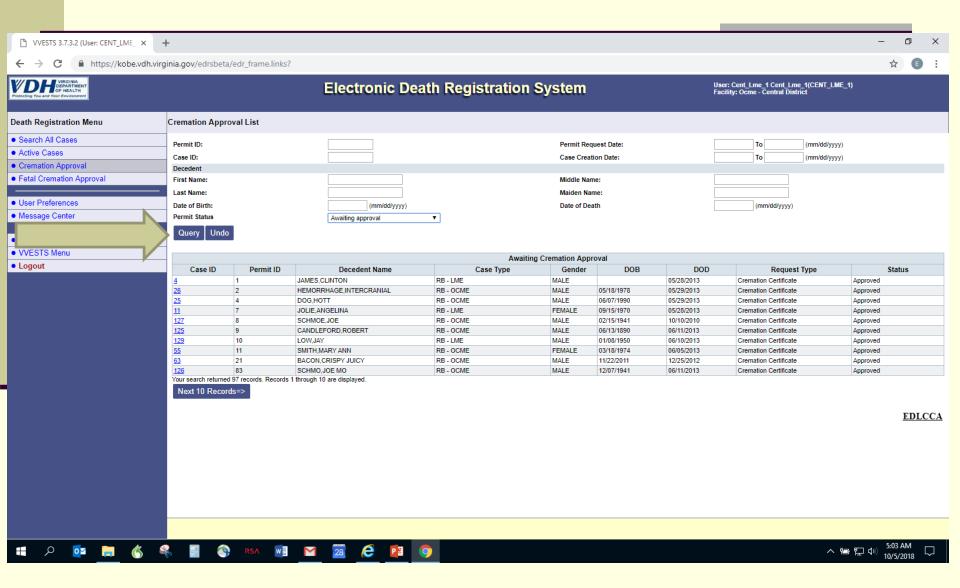
Search, scroll, or sort



Sorting



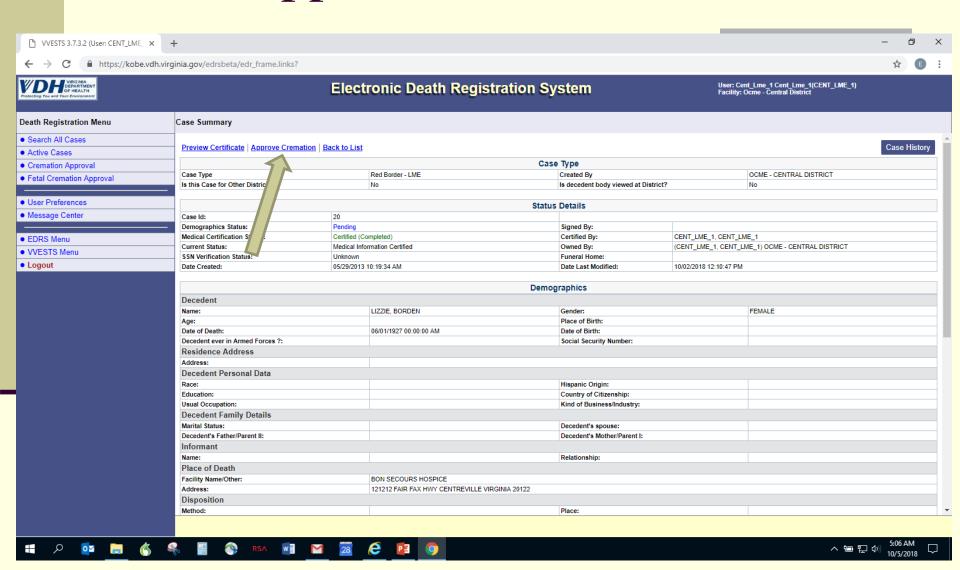
Query after searching or sorting



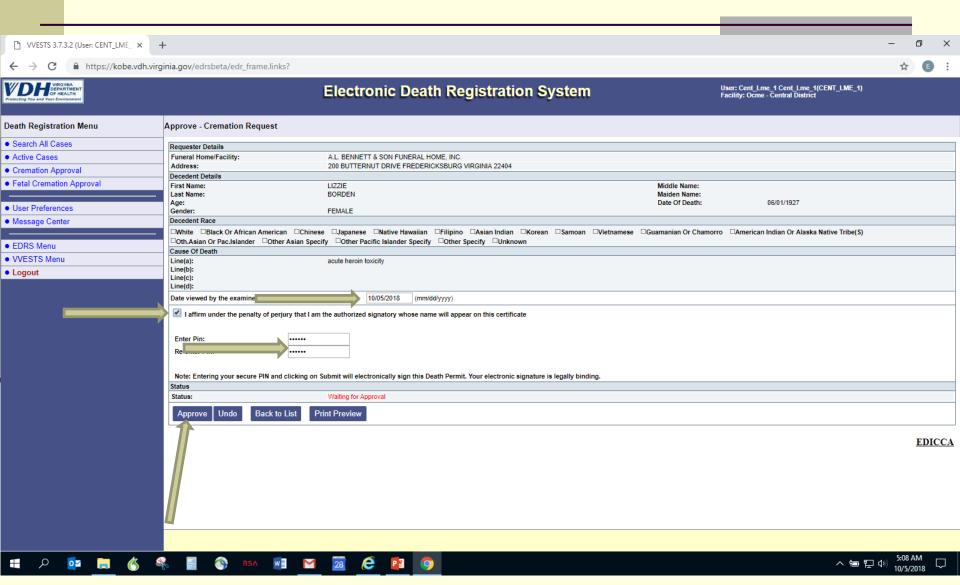
After sorting

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Select approve cremation



Date, affirm, pin, approve



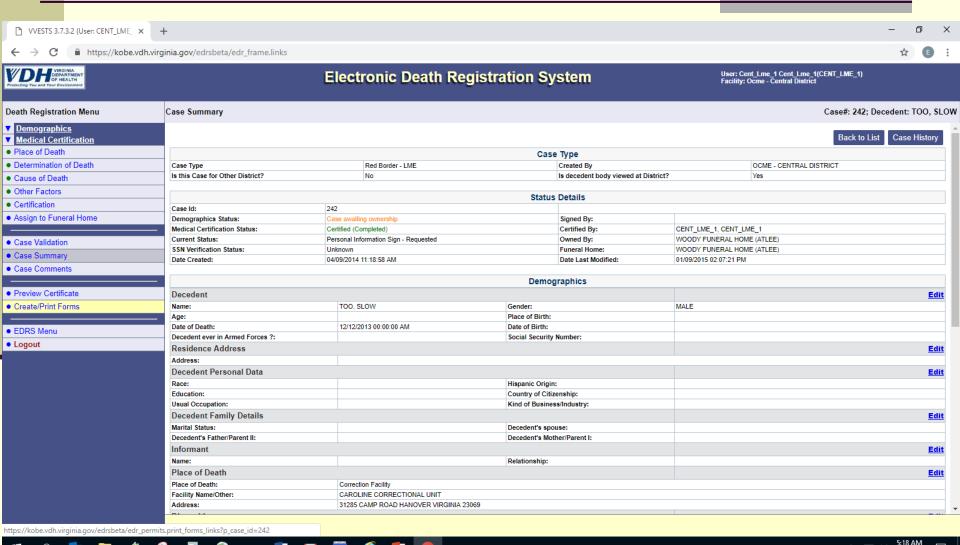
Without FH starting, LME can start cremation, if FH is assigned



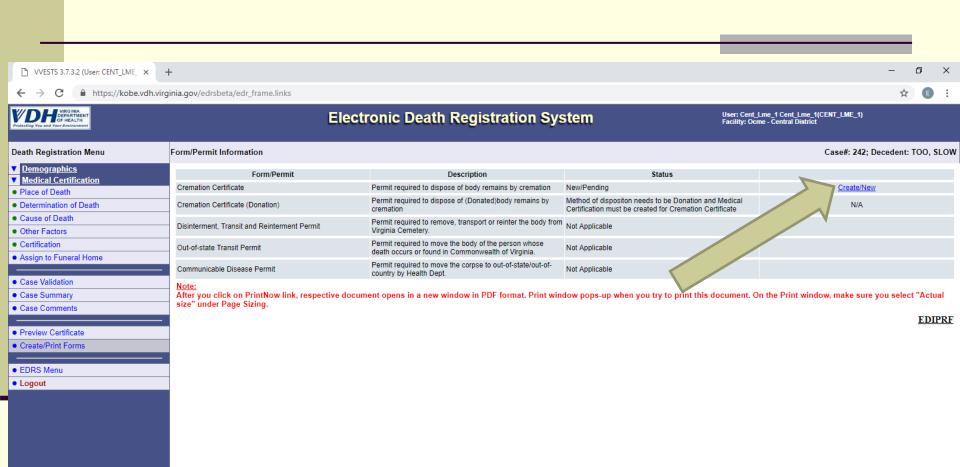
EDVHOM



After selecting decedent, choose Create/Print Forms



Choose Create/New

















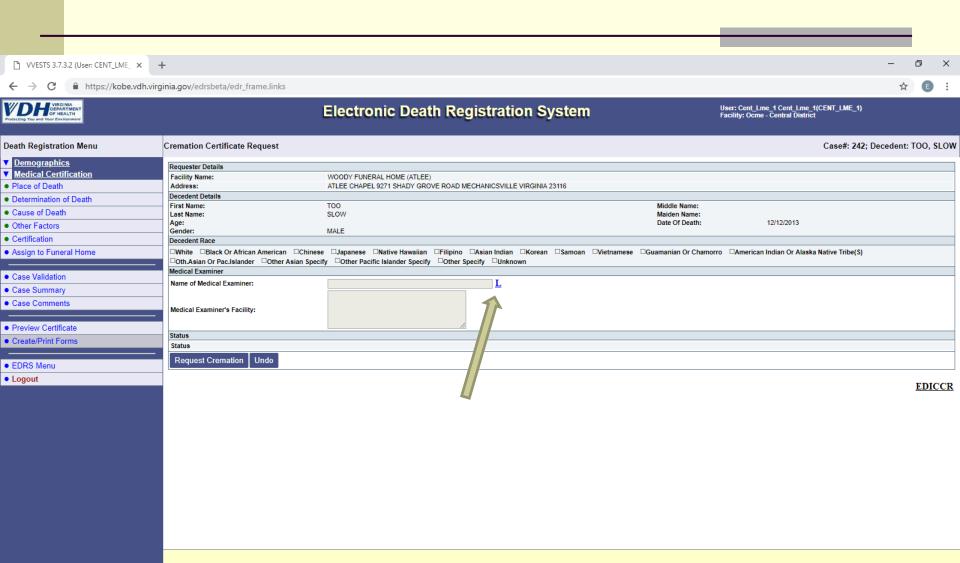




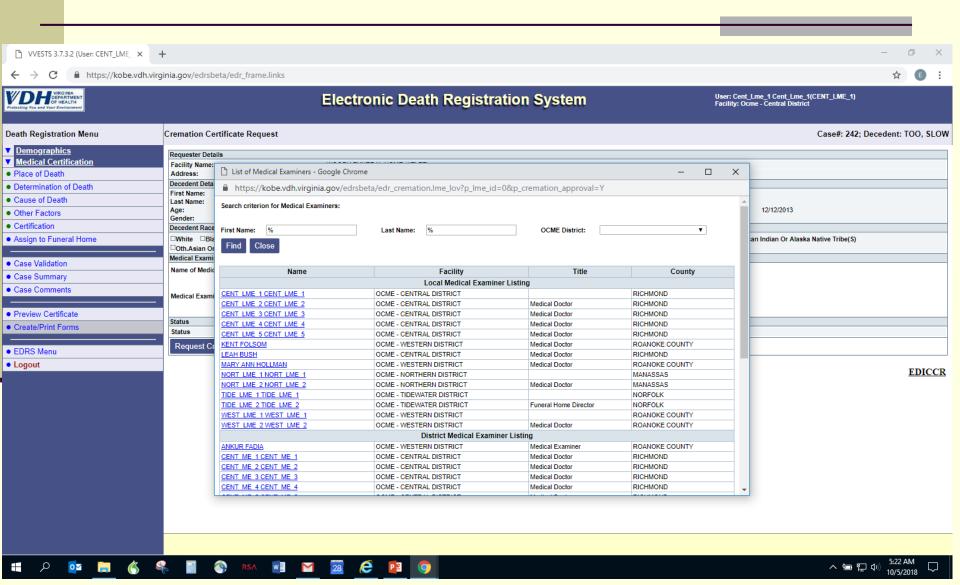




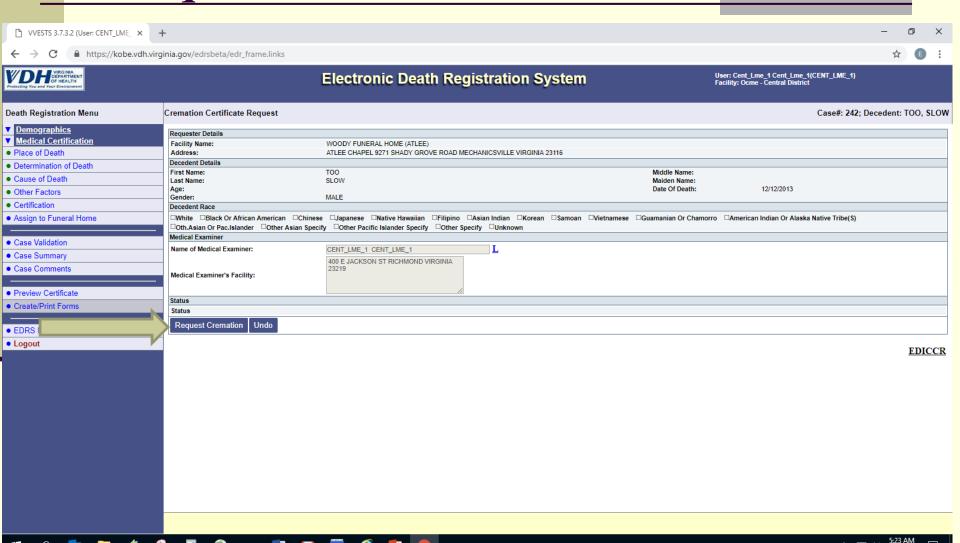
Click the "L" link



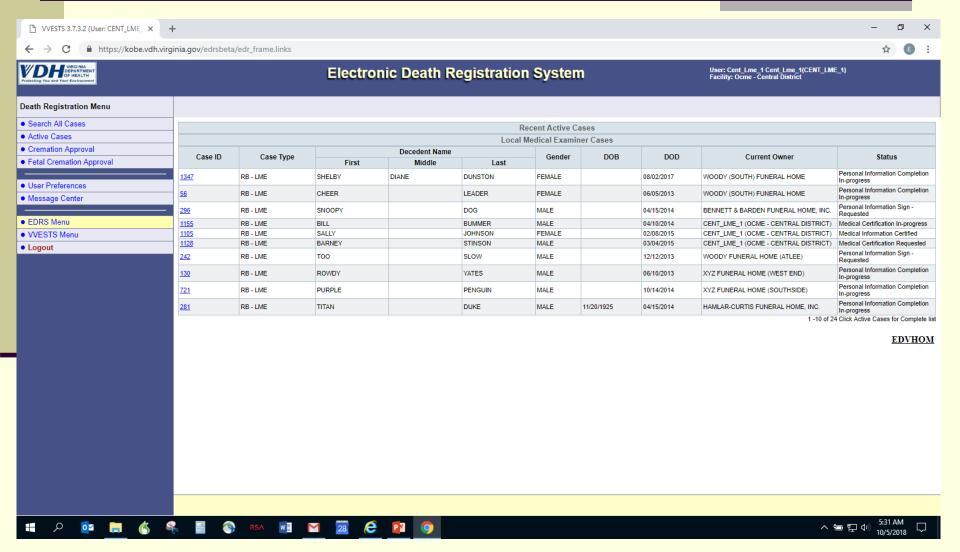
Select your name from the list



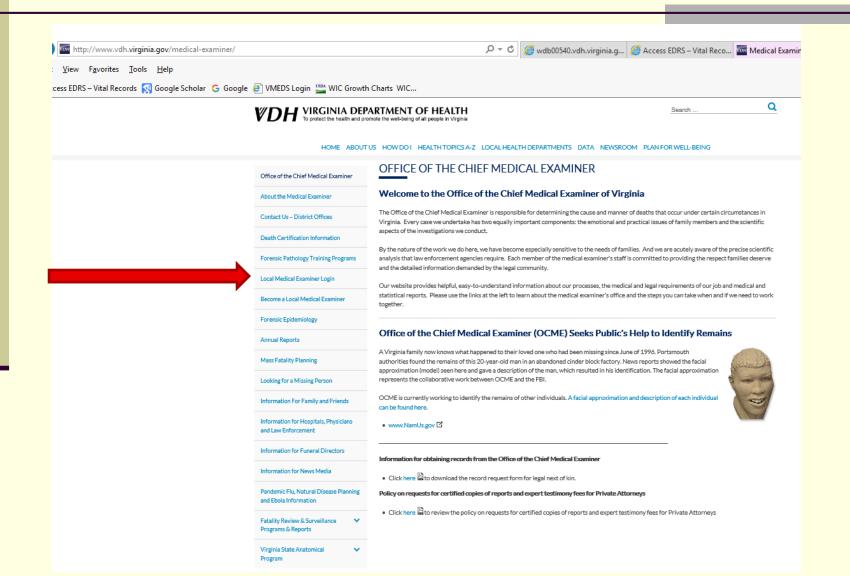
Your name is populated, select Request Cremation



Go back to EDRS main menu and finish the approval process



LME internal site



LME site – password protected

- Forms: body diagram, cremation certificate, death scene investigation, tox data sheet, scene placard
- Postmortem specimen collection kit: instructions
- Education & training materials: training checklist, photographing death scenes, instructions for deaths scene investigation report
- Upcoming training & conference information

Working with Medicolegal Death Investigators

- Intake new cases & inquiries from LME, LEA, hospitals, funeral homes, family members, OPO's, etc
- Coordinate OPO recovery
- Assist in identification
- Obtain supporting documentation for the ME investigation, follow up investigation
- Scene investigation, doll scene reenactments
- Take in bodies
- Pathologist should be available for consultation

When to notify OCME immediately

- Declared disaster
 - Weather related, special events
- Covert burial
- Public heath interest
 - Emerging infectious disease
 - Contact treatment
- Mass fatality

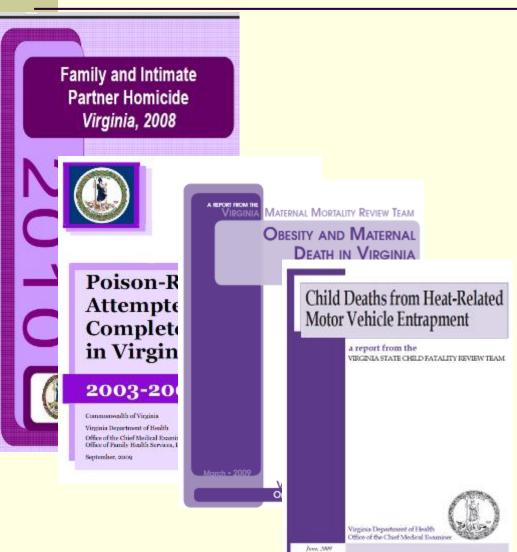
Proper Identification

- Investigative agency plan on identifying the remains?
 - Scene investigation
 - Enlist family & associates to identify medical & dental information
 - Notify district office
 - Provide demographics
- Forensic Methods Fingerprints (SID number), X-ray, Dental, DNA comparison
- Visual facial, body features
- Circumstantial

Unidentified or Skeletal Remains

- Terms such as "John Doe," "Jane Doe," or "Baby Doe" are not used.
- Use of "BTB" of "PTB"
- List based on sex, race, and location.
 - Unidentified Black Male, 1234 Colley Ave, Norfolk.
- If the remains are skeletal, are they human?

Surveillance and Review



- Family and Intimate Partner Violence Surveillance
- Virginia Violent Death Reporting System
- Child Fatality Review
 - State and local
- Maternal Mortality Review
 - All sudden, unexpected deaths of pregnant or recently pregnant women should be referred to the district office for possible autopsy
- Family and Intimate Partner Violence Fatality Review



Office of the Chief Medical Examiner Annual Report 2016



Commonwealth of Virginia
Virginia Department of Health
Office of the Chief Medical Examiner, 2016
Compiled by Kathrin 'Rosie' Hobron, MPH
March 2018

Any Questions?

